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Physician Discipline: Considerations for a National Policy

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PHYSICIAN DISCIPLINE:
CONSIDERATIONS FOR A NATIONAL POLICY

by Oren L. Zeve*

I. A PREEXISTING CONDITION

The American electorate has a short institutional memory.[1] If an individual were to have the apparent memory lapses the voters collectively display, a series of diagnostic medical tests would be appropriate to identify the causes of the problem. No tests can be performed on the national psyche as a whole, however; politicians may prefer it that way, particularly at election time.

The electoral politicking over health care policy as one of the ills that plague America's citizens is an instance of this memory loss. Medical malpractice, the rising costs of medical care, and the lack of and under-insurance of millions of people affect lives every day, with consequences not just for individuals, but for society as a whole. An institutional amnesia, however, has caused the public to forget the observation made even ten years ago that the "health care crisis has been with us for a considerable

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1. *See, e.g.*, Jack Germond & Jules Witcover, *Republicans' 'Stature Gap' Talk is Nonsense*, ATLANTA J. & CONST. Dec. 20, 1991 at A:16. "[T]he public's being pulled this way and that way by conflicting or competing values isn't simply an occasional occurrence but instead a fundamental, recurring characteristic of opinion on a wide range of policy questions." DAVID YANKELOVICH, COMING TO PUBLIC JUDGMENT: MAKING DEMOCRACY WORK IN A COMPLEX WORLD 32-33 (1991) (quoting *Ten Years of Public Opinion: An Ambivalent Public*, PUBLIC OPINION Sept-Oct 1988 at 21).

time now."[2] The federal government in Washington has been aware of the "crisis" in health care for four decades,[3] and in the

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2. Philip C. Kissam, *Government Policy Toward Medical Accreditation and Certification: The Antitrust Laws and Other Procompetitive Strategies*, 1983 WISCONSIN LAW REV. 1, 21 (1983). Professor Kissam's article provides an excellent description of medical credentialing for both the novice and expert. It would be difficult at best to approach the topic of this article without being familiar with his analysis.

3. The mainstream media have reported consistently on the "health care crisis" as a concern for national lawmakers. The Nixon White House wrestled with the problem early in its first administration. Leone Baumgartner, *Health Care System - A Sick but Curable Patient*, N.Y. TIMES, December 20, 1969, at 30; Richard D. Lyons, *Administration Seeks Short-Run Gains in Nation's Medical System*, N.Y. TIMES Jan. 12, 1970 at 19; Richard D. Lyons, *Some Democrats Laud Nixon Plan*, N.Y. TIMES Feb 20, 1971, at 28. The 1976 campaigns included conflicts within the Republican party as to the best solution, *Where Ford and Reagan Stand on Issues - In Their Own Words*, U.S. NEWS & WORLD REPORT, March 1, 1976 at 16, and President Carter continued to hear from the ranks of business during his administration. A.F Ehrbar, *A Radical Prescription for Medical Care*, FORTUNE, February 1977, at 3; Regina Herzlinger, *Can We Control Health Care Costs?*, HARVARD BUSINESS REV., Mar./Apr. 1978, at 102.

After nearly four years of President Reagan's tenure in office, health care was a topic for both business and medical interests. *The New Health Care Crisis Must Be Faced*, BUSINESS WEEK, December 26, 1984, at 222; *1984 Presidential Candidates' Health Care Platforms*, HOSPITALS, J of the Amer. Hosp. Ass'n, Sept. 1, 1984; Linda E. Demkovich, *Businesses Drive to Curb Medical Costs without Much Help from Government*," 16 NAT'L J. 1508 (1984). The Clinton administration wants a comprehensive plan, the Health Security Act (HSA), to address the majority of the problems faced by the health care system. *See* WHITE HOUSE DOMESTIC POLICY COUNCIL, HEALTH SECURITY: THE PRESIDENT'S REPORT TO THE AMERICAN PEOPLE (1993); *see also* Health Security Act, H.R. 3600, 103d Cong. 1st Sess. (1993).

Even before the United States existed, health care was regulated by government. *See* R. Scott Jones, *Organized Medicine in the United States*, 217 ANNALS OF SURGERY 423-24 (1993) (describing colonial laws from 1639 and the mid-1700s). There probably has never been a time in the United States when a health care concern of some sort did not exist for the government.

politics of health for most of the century.[4]

Coverage and payment reform, regardless of whether they involve the current system of multiple insurers or movement toward a single-payer,[5] fail to address a perhaps more fundamental question. The individuals who provide health care services must be qualified to treat their patients. Attention has been paid to the opportunity to choose a provider, but it must also address the quality of physicians and the allied health professionals themselves.[6]

Although the number of applications to medical school has recently increased,[7] only twenty-five years ago the profession was

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4. *See generally*, JAMES A. MORONE, THE DEMOCRATIC WISH: POPULAR PARTICIPATION AND THE LIMITS OF AMERICAN GOVERNMENT at 257-61 (1990) (summarizing national health proposals before and after the world wars); Al Gordon, *Health Care - From Truman to Clinton*, NEWSDAY, Oct. 18, 1993 at 41; Jonathon Greenberg, *Give 'em Health, Harry*, NEW REPUBLIC, October 11, 1993.

5. Contrary to the political claims that a reform of health care payment systems at the federal level will lead to "socialized medicine," the oft-cited examples of the medical systems in Great Britain and Canada have significant differences. The former operates with doctors *employed* by the government for the provision of care, while in the latter the government is the source of the ultimate *payment*, as a "single-payer system." Proponents of a single-payer system advocate adoption of this Canadian model, not the British program. Robert Dreyfuss, *The Big Idea*, MOTHER JONES May/June 1993, at 18,22. *See also* Carol Gentry, *A Prescription for Understanding Health Care Reform*, ST. PETERSBURG TIMES, Sept. 23, 1993 at 10A; Trudy Lieberman, *Focus on Healthcare: A Handbook for Journalists*, 32 COLUM. JOURNALISM REV. 37 (1993).

6. The Clinton proposal raises quality of care as a goal of the system. The plan asserts that the Health Security Act will improve quality by developing "guidelines for effective medical care for specific conditions and illnesses," WHITE HOUSE DOMESTIC POLICY COUNCIL, *supra* note 3, at 61, while simultaneously claiming not to "second-guess decisions made by doctors and their patients." *Id.* at 62-3.

7. *Medical School: Applications Rise for 4th Year*, WASHINGTON POST, Nov. 10, 1992 at Z5; *The Week in Healthcare*, MODERN HEALTHCARE, Oct. 4, 1993, at 16.

"wounded" by "dissatisfactions, diffidence, [and] ethical decay."[8] Professional dissatisfaction developed in part from a rapid increase in liability in the field of medical malpractice, which distracted physicians from the self-adopted responsibility of treating illness.[9] While the current debate about the economics of health care includes the consequences of what some call a malpractice "crisis,"[10] it focuses much more on affordability in health care than on quality.[11]

Medical malpractice claims have served for many years as society's most aggressive public response to monitoring incompetent doctoring. Economic reformers target the malpractice system as a prime scapegoat for the upward spiral in the cost of medical care.[12] One conclusion that can be drawn from

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8. Bernard J. Ficarra, *Legal Medicine: The Auxiliary to Bioethics*, in LEGAL MEDICINE 203 (C.H. Wecht, ed., 1992).

9. One physician has claimed that the medical profession suffers from "an infection... named consumer-driven, profit-oriented capitalism." R. Scott Jones, *Organized Medicine in the United States*, 217 ANNALS OF SURGERY 423, 428 (1993)(emphasis omitted). "[I]f capitalism invades a profession that is supposed to be looking after sick people as its primary goal, that profession will get sick. That is exactly what has happened." *Id. See generally*, Edmund D. Pellegrino, *The Medical Profession as a Moral Community*, 66 BULL. N.Y. ACAD. MED. 221 (1990).

10. *See e.g.*, Roger D. Blair & Marvin Dewar, *How to End the Crisis in Medical Malpractice Insurance*, CHALLENGE, Mar/Apr 1988, at 36.

11. *See* Erik P. Eckholm, *Less Cost vs. Less Care*, N.Y. TIMES, Sept. 20 1993, at A1; Ruth Simon, *A Flawed Remedy: Managed Care*, MONEY, April 1993, at 114. *But cf.* Lu Ann Aday, *Equity, Accessibility and Ethical Issues: Is the U.S. Health Care Reform Debate Asking the Right Questions?* 36 AMER. BEHAV. SCI. 724 (1993).

12. The threat of malpractice increases costs by forcing doctors to require additional tests in order to prevent second-guessing of their diagnosis and course of treatment. Julie Kosterlitz, *Paying for Miracles*, 26 NAT'L J. 1967 (1993) ("tests of dubious value"); Merrill Goozner, *Health Care Puzzle: More is Less*, CHICAGO TRIBUNE, July 8, 1991, at 1-C (discussing "defensive medicine"). *But see* Kenneth Jost, *Defensive Medicine: Cost Savings Uncertain*, ABA J., May

malpractice litigation is that some physicians, "a small percentage," lack basic competence, while others are unprepared to undertake specific procedures.[13] Thus, if the advocacy for America's health security includes quality of care as a requirement, action must be taken to preserve a community of competent physicians.

In 1986, Otis R. Bowen, secretary for Health and Human Services, testified before a congressional committee on malpractice reform that a significant step toward reform would include "thorough and comprehensive state surveillance" of physician competence.[14] Congress periodically considers legislation pertaining to medical personnel, but traditionally the states have regulated through their police powers physicians and other practitioners, as well as aspects of health care such as insurance companies.[15] The states have served as the primary regulators of the profession through two parallel institutions: the courts as the forum for trying medical malpractice cases, and the physician licensing and discipline boards specifically charged with administrative control.

1993 at 71. The Health Security Act would eliminate the liability of physicians who have followed the appropriate practice guidelines. *See* WHITE HOUSE DOMESTIC POLICY COUNCIL, *supra* note 3, at 79; see also Health Security Act §5312 (creating a pilot program). Likewise, the skyrocketing costs of malpractice insurance have driven otherwise-qualified practitioners out of their chosen fields, particularly obstetrics. *See Federal Incentives for State Health Care Professional Liability Reform Act of 1985: Hearings on S1804 Before the Senate Committee on Labor and Human Resources*, 99th Cong., 2d Sess. (1986) [*hereinafter Federal Incentives*]; Gary Spencer, *Cuomo Urges Malpractice No-Fault Fund*, N.Y.L.J., June 21, 1991 at 1.

13. *Federal Incentives*, *supra* note 12, at 597 (statement of Otis R. Bowen, secretary of the U.S. Department of Health and Human Services).

14. *Id.* at 598.

15. "Although federal [quality-of-care] activities are more pervasive and receive more attention... [o]ne cannot discuss... basic issue[s]... without acknowledging state jurisdiction." Adrienne Lang, *The Influence and Activities of Government on Quality of Care*, 30 INT'L ANESTHESIOLOGY CLINICIAN, Spring 1992, at 57.

Given the focus on revamping health care financial policy at the national level, it seems appropriate to ask whether other aspects of the system should be addressed at that level. Neither the standards nor the ability of a physician to practice medicine depends on his respective state; the human body is the same everywhere.[16] While the process of regulating doctors has remained with the states, there is a growing recognition that state disciplinary and medical boards are notoriously bad at assuring the qualifications and competence of medical professionals.[17]

Opponents of federal involvement in health policy insist that health care must remain the responsibility of the states.[18] Individual states retained the authority to regulate this subject in the federal system in the Constitution, particularly through the Tenth Amendment.[19] However, the rigidity of this view neglects the fact that "the federal government is the only player with a

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16. The most prominent federal initiative connecting quality and incompetence, the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§11101-11152 (1988), encourages the use of "explicit, more nationally uniform criteria to examine patterns of care and patterns of outcomes." Stephen F. Jencks & Gail R. Wilensky, *The Health Care Quality Improvement Initiative: A New Approach to Quality Assurance in Medicare*, 268 JAMA 900 (1992).

17. *Physician Discipline: Can State Boards Protect the Public?: Hearing Before the Subcommittee on Regulation, Business Opportunities, and Energy of the Committee on Small Business*, 101st Cong., 2d Sess. (1990) at 2 (introductory remarks of Rep. Ron Wyden, subcommittee chairman) [*hereinafter Physician Discipline*]. *See also* U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, MEDICAL LICENSURE AND DISCIPLINE: AN OVERVIEW (1986).

18. In the current health insurance debate, the Hawaiian program of universal coverage is proffered by opponents of federal intervention as an example of state success. *See* William F. Buckley, Jr., *What Happened to Federalism?*, NATIONAL REVIEW, Nov. 16, 1992, at 71. Yet, Hawaii has several social characteristics which may make the example unwarranted. *See generally* Bill Turque, et.al., *Experimental States*, NEWSWEEK, May 17, 1993 at 39.

19. "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." U.S. CONST., amend. X.

national mandate and national constituencies of both providers and patients;" and physicians must "try to work with it rather than against it."[20]

This article will look at physician licensing and discipline in the American constitutional system. Part II surveys the main methods of initially credentialing physicians: state licensing and medical board certification. The third section contends that views restricting federalism to a bright line rule in the Constitution should be rejected. The Constitution represented a deliberate movement towards a more national government, notwithstanding its "federalist" labelling. Finally, some proposals for greater involvement by Washington in eliminating incompetent physicians will be considered in Part IV.[21]

II. LICENSE LICENTIOUSNESS?

Physician licensing practices date back several centuries.[22] Europeans adopted them as early as the Middle Ages; variants existed across the several nations. Although England first implemented related laws in 1511, the practice did not initially cross the Atlantic to the colonies. Over time, the individual colonies initiated regulations of their own. In one case, a state

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20. Lang, *supra* note 15, at 70. *See also* Sylvia A. Law & Barry Ensminger, *Negotiating Physicians' Fees: Individual Patients or Society? (A Case Study in Federalism)*, 61 N.Y.U.L.REV. 1, 87 (1986) ("not whether the states or federal government has responsibility... but rather that someone must").

21. "Only a few disciplinary actions by State Boards appear to stem from outright incompetence or careless work... [but] we simply don't know the true extent of inferior medicine being practiced today or the impact it may have on patient care." *Federal Incentives*, *supra* note 12, at 599 (statement of Otis R. Bowen).

22. ROBERT C. DERBYSHIRE, MEDICAL LICENSURE AND DISCIPLINE IN THE UNITED STATES 1 (1969). The historical material here comes from chapter 1 of this book. *See also* STANLEY J. GROSS, OF FOXES AND HENHOUSES: LICENSING AND THE HEALTH PROFESSIONS ch. 4 (1984).

directed that university-trained physicians could charge higher rates for medical services than their apprenticed counterparts. By the end of the nineteenth century, every state engaged in some sort of licensing process, usually requiring an examination of applicants.

Despite the long history, the propriety of physician regulation still stirs debate.[23] The object of licensing should be a determination that a particular individual is competent to engage in the practice of medicine.[24] "The rationale for state regulation in this area is the patient's inability to safeguard his own interest... [s]ince the patient has no means to evaluate his physician's competence."[25] Ample evidence dispels that rationale; licensing serves the interests of physicians and they, like other professionals, actually seek out the protection state regulation can provide.[26] One author has flatly suggested that "licensing fails to assure its legitimate purpose of furthering competence and honesty on service."[27] Even if an "initial license" does offer guidance to consumers on competence, a public health official has noted that

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23. *See e.g.*, GROSS, *supra* note 22, at 3 ("[L]icensing... has become worse than the problem it is said to address"); Elizabeth Graddy, *Interest Groups or the Public Interest -- Why Do We Regulate Health Occupations?* 16 J. HEALTH POL., POL'Y & LAW 25 (1991) (assessing the impact of regulation on health professionals); Jaclyn Faglie Low, *Another Look at Licensure: Consumer Protection or Professional Protectionism?* 46 AMER. J. OCCUPATIONAL THERAPY 373 (1992).

24. *See* Donald G. Langsley, *Medical Competence and Performance Assessment: A New Era*, 266 JAMA 977 (1991) (outlining various methods of evaluating practitioner skills).

25. FRANK P. GRAD & NOELIA MARTI, PHYSICIANS' LICENSURE AND DISCIPLINE 55 (1979). *See also* GROSS, *supra* note 22, at 16-19 ("public welfare purposes").

26. *See* Low, *supra* note 23, at 373 ("a lack of documentation of consumer protection" but "evidence of self-serving"); GROSS, *supra* note 22, at 19-20 (offering the advantages to various occupations that desired state licensing).

27. GROSS, *supra* note 22, at 3.

there is no "guarantee that every physician will *maintain* the needed knowledge and skills" over time.[28]

Licensing and certification are the two ways to identify physicians who possess the requisite knowledge and skills to practice medicine.[29] State boards of medical examiners require minimum education and skill-training levels before they will license medical practitioners.[30] Most states demand that physicians-to-be graduate from an "accredited" medical school, pass a now-uniform national exam, and participate in a residency program.[31] In addition to these educational criteria, personal

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28. Alfred Gellhorn, *Periodic Physician Recredentialing*, 265 JAMA 752 (1991)(emphasis added). Gellhorn, who chaired the New York State Advisory Committee on Periodic Physician Recredentialing, observed that the need for maintenance of knowledge has "tempered [the medical profession's] objection to the concept" of recredentialing. *Id.* at 752.

29. Most of the medicine in the United States, however, is practiced by lay people engaged in such simple pursuits as taking an aspirin or bandaging a cut. Regulation of this "practice" of medicine would be entirely unworkable, although some might argue that no drug, even aspirin, should be available as over-the-counter medication. *See* Robert M. Veatch, *Federal Regulation of Medicine and Biomedical Research: Power, Authority, and Legitimacy*, 75 THE LAW-MEDICINE RELATION: A PHILOSOPHICAL EXPLORATION 9 (Stuart F. Spicker, Joseph M. Healey Jr., & H. Tristan Engelhardt, eds., 1981).

30. Licensure operates as only one method of state regulation. Other less restrictive controls include certification, which is different from specialty certification in the medical field, and registration. Graddy, *supra* note 23, at 26.

31. *See* Kissam, *supra* note 2, at 8. In December 1993, a single test, the United States Medical Licensing Examination, replaced the previous collection of exams, which included one specifically for graduates of foreign, or non-U.S., medical schools. *See* Alton I. Sutnick, Marie L. Shafron, & Marjorie P. Wilson, *Impact of the New United States Medical Licensing Examination on the Certification Process of the Educational Commission for Foreign Medical Graduates*, 31 INT'L J. OF DERMATOLOGY 798 (1992). Foreign medical graduates encounter special difficulties in obtaining licenses to practice in the U.S. *See generally*, Arthur Osteen, *Licensure and International Medical Graduates*, 266 JAMA 956 (1991).

background is also considered.[32] Receiving a license to practice from the state confers legal authority to engage in the profession.[33]

Certification, like licensing, provides a modicum of information to others, including the fact that an individual meets minimum standards set by others in the profession or specialty.[34] Organized boards of physicians have developed separately from the states' credentialing programs, and in some cases, the physician boards are as powerful as licensing agencies.[35] The American Board of Medical Specialties, the umbrella organization for specialty boards, currently includes twenty-four member boards.[36] The specialty boards branch into subspecialties that certify over seventy areas of practice.[37]

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32. DEPARTMENT OF HEALTH & HUMAN SERVICES, OFFICE OF INSPECTOR GENERAL, MEDICAL LICENSURE AND DISCIPLINE 2 (1986). A hospital hiring committee may consider many additional details that may impact on the relationship to the hospital, such as locations of both home and office, before granting full institutional privileges. *See generally* GEORGE D. POZGAR, LEGAL ASPECTS OF HEALTH CARE ADMINISTRATION 175-82 (5th ed. 1993).

33. "Licensure restricts the scope of practice, making it illegal for an unlicensed person to perform the service." Graddy, *supra* note 23, at 26. *But see* GRAD & MARTI, *supra* note 25, at 54-55 (suggesting the purpose of licensure as related to discipline).

34. *See* Kissam, *supra* note 2, at 55. For a more complete comparison of these two processes across several health occupations, see DENNIS S. FALK, NEIL WEISFELD, & DAVID TOCHEN, PERSPECTIVES ON HEALTH OCCUPATIONAL CREDENTIALING: A REPORT OF THE NATIONAL COMMISSION FOR HEALTH CERTIFYING AGENCIES 7-22 (1979).

35. Private credentialing programs are subject to antitrust laws. *See* Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975); *see generally* Kissam, *supra* note 2, at 2-4, 55-63.

36. Jones, *supra* note 9, at 426. Boards have been in existence since 1916. *Id.*

37. Alma R. George, *Physician Certification*, 83 J NAT'L MED'L ASS'N 857 (1991). The development of the numerous subspecialties forced the ABMS to reemphasize the qualifications represented by a "general certificate" that signals

Both licensing and certification have drawbacks. In the opinion of some, licensing offers an opportunity for members of the profession to restrict others from practicing and thus to assure non-competition.[38] While no one would suggest that incompetent physicians be allowed to practice, today licensing itself does not necessarily prevent that from occurring. The statutes of the late 1800s and early 1900s targeted "quackery, commercial exploitation, deception, and professional incompetence," but do not fulfill that role today.[39] Consequently, licensing may simply

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overall competence, inclusive of subspecialties, and that is granted by a specialty board. *Id.* The majority of the specialty boards issue a "time-limited" certification which must be renewed periodically in order to maintain the status. *See Task Force on Recertification, Time-Limited Certification and Recertification: The Program of the American Board of Internal Medicine*, 114 ANNALS OF INTERNAL MED. 59 (1991) [hereinafter *Task Force*] (announcing the board's new policy); *see also* George, *supra*, at 857 (outlining the certification process generally).

38. "By their very nature, licensure restrictions are anticompetitive." Shirley V. Svorny, *Physician Licensure: A New Approach to Examining the Role of Professional Interests*, 25 ECONOMIC INQUIRY 497, 507 (1987). *See generally* MILTON FRIEDMAN, CAPITALISM AND FREEDOM chap. 9 (1962); and ALAN L. SORKIN HEALTH MANPOWER: AN ECONOMICS PERSPECTIVE 79 (1977). Sorkin describes Reuben A. Kessel's proposal which focuses on medical skill "outputs," as opposed to "inputs": allow anyone to take the exam, regardless of training, and then engage in periodic testing for licensure renewal. *Id.* at 79 (citing Kessel, *The AMA and the Supply of Physicians*, 35 LAW & CONTEMPORARY PROBLEMS 267 (1970). When professional groups establish credentialing programs,"the observed consequences always seem to be these two: the exclusion of certain groups, whether by intention or not, and the establishment of mediocre performance standards." James Fallows, *The Case Against Credentialism*, ATLANTIC MONTHLY December 1985, at 49, 64 (quoting a business consultant).

39. Low, *supra* note 23, at 373 (quoting R. Roemer, *Health Service Developments: Their Impact on Regulation and Functions of Rehabilitation Personnel*, ARCHIVES OF PHYSICAL MEDICINE AND REHABILITATION 183 (1980)).

function to drive health costs higher with no appreciable return for the expense.[40]

More radical critiques of licensing have charged that the system creates a "monopoly" for an elite few to define "disease," "sick," and the proper course of treatment.[41] While the system does have supporters,[42] the growing complexities of medical practice and the need for physician accountability triggered the certification of physicians by the various specialty boards,[43] an alternative to the less than "optimal" present conditions.[44] Certification should replace licensing because it provides roughly the same amount of information while increasing free choice in the market for various medical services.[45] This process is not immune to abuse, however.

Certification of medical professionals applies in several areas of health care. Medical schools are all accredited or regulated by the American Medical Association (AMA) as well as

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40. *Id.* Many routine medical procedures can be performed by non-physicians, such as nurse practitioners, midwives or physician's assistants, while doctors remain in the background in the event their more specialized skills are required.

41. GEORGE J. ANNAS, et al., AMERICAN HEALTH LAW, at 673 (citing IVAN ILICH, MEDICAL NEMESIS (1976)). A recent move by the National Institutes for Health to establish an Office of Alternative Medicine may increase the attention paid to nontraditional American providers as reputable sources for diagnosis and treatment. *See* Anastasia Toufexis, *Dr. Jacobs' Alternative Mission*, TIME, March 1, 1993 at 43.

42. *See* ANNAS, *id.*

43. *Task Force*, *supra* note 37, at 59.

44. Graddy, *supra* note 23, at 45; *see also* Shirley Svorny, *Should We Reconsider Licensing Physicians?*, 10 CONTEMP. POL'Y ISSUES 31 (1992).

45. Svorny, *supra* note 38, at 497. Certification normally requires equal or more stringent requirements than licensing. *See* Blair & Dewar, *supra* note 10 (suggesting revisions to the licensing system as a solution to the malpractice crisis). *See also* Langsley, *supra* note 24, at 997-8.

by the Association of American Medical Colleges.[46] The Joint Commission on Accreditation of Healthcare Organizations (controlled by the AMA, the American Hospital Association, and the professional colleges of both physicians and surgeons) regulates the accreditation of hospitals.[47] Most specialists, as well as the "paraprofessionals" (e.g., nurses or chiropractors), certify members of their respective communities.

These private accreditation organizations convinced many state legislatures that licensing should be coordinated with their private activities. It is no coincidence that both the AMA and the states require accreditation of medical schools.[48] Many hospitals, furthermore, require specialty board certification before extending full privileges to a physician.[49] This has created an incestuous credentialing process as the different certifiers work with each other in setting their standards.

All the private systems suffer from an "inherent conflict of interest" that can harm consumers by affecting quality and cost.[50] Mutual standardization may cause a less-than-ideal situation.[51] One consequence may be education and residency standards that

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46. *See* Kissam, *supra* note 2, at 8, 34.

47. *Id.* at 9.

48. *See generally*, KENNETH M. LUDMERER, LEARNING TO HEAL: THE DEVELOPMENT OF AMERICAN MEDICAL EDUCATION (1985).

49. *See* POZGAR, *supra* note 32, at 175-78 (listing employment considerations for hospital governing boards); *but see* 42 C.F.R. § 482.12(a)(7) (privileges may not be "dependent solely upon certification, fellowship, or membership in a specialty body or society").

50. Kissam identifies three types of conflicts: (1) the public interest vs. private economic interests in preventing competition; (2) the public interest vs. the provision of the best possible care; and (3) the public interest in impartial decision making vs. prevailing scientific/medical paradigms. Kissam, *supra* note 2, at 20-1.

51. *See id.* at 22-3 (concluding that "ideological and technological factors" may influence more than economics).

have an "unnecessary uniformity." Other problems include the possibility of reductions in competition among non-discrete specialty providers and over-utilization of health care services.[52]

The interplay between licensure and certification has not resolved the fundamental difficulty of establishing a policy that will not simply identify capability but also prevent incompetence. Licensure, and its potential revocation, should encourage doctors to "behave in a manner consistent with patients' interests."[53] The medical examiners who *can* revoke or suspend a license or mandate other discipline for wayward doctors frequently *do not* revoke it, even in some of the more egregious cases.[54] One medical consumer advocate has suggested that, in New York alone, over ten thousand incompetent doctors may be practicing medicine regularly on unsuspecting patients.[55] Thus, unless one advocates abolishing physician licensing entirely, the practice represents an accepted, basic step in creating and maintaining a pool of qualified doctors.

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52. *Id.* at 12-18.

53. Svorny, *supra* note 38, at 499. At the same time, patients, as consumers, should be prepared themselves to ask the questions necessary to identify good doctors. *See* Rita Rubin, *When and How to Challenge Your Doctor*, U.S. NEWS & WORLD REP. May 10, 1993 at 63.

54. *See generally Physician Discipline*, *supra* note 17; Tim Friend, *Diagnosing Bad Doctors*, AMERICAN HEALTH 11 (November 1990) (discussing a compilation of 6892 "questionable doctors" who still have licenses).

55. *Physician Discipline*, *supra* note 17, at 5 (testimony of Laura Wittkin, executive director of Stop Hospital and Medical Error, Inc. (SHAME)). But see Norton Spritz, *Oversight of Physicians' Conduct by State Licensing Agencies: Lessons from New York's Libby Zion Case*, 115 ANNALS OF INTERNAL MED. 219 (1991) (criticizing the disciplining of two doctors under a faulty procedure). *Cf.* Joseph Post, *Medical Discipline and Licensing in the State of New York: A Critical Review*, 67 BULL. N.Y. ACAD. MED. 66, 95 (1991) ("there is urgent need for reform").

III. RED, WHITE, AND BLUE CELLS

The current system, which relies on the states to license and to discipline, has major gaps in achieving the policy goal of preserving quality care in medical practice. Although after-the-fact review of medical decisions does not assure quality care at the time of service, it offers a method for checking the actions of doctors.[56] Bad doctoring may be the product of any number of factors. Both physical and mental illness as well as substance abuse affect a physician's skills. Treating these problems often requires a response other than license revocation.[57]

Disciplinary systems should respond to competency concerns but are often ineffective because state boards have been under-funded and understaffed. Another problem involves the lack of uniformity across the states. Various states require slightly different license requirements. Licensed physicians frequently are authorized to practice in a second jurisdiction via reciprocity laws, or endorsement.[58] Revocation of that same license in one state does not automatically affect privileges in another, so doctors can travel from one state to another. Sanctionable behavior in one jurisdiction may be ignored in another.[59]

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56. *Cf.* Lang, *supra* note 15, at 69. Lang distinguishes between "quality assurance" as an error and correction process, and "improvement" as "prospective behavior modification." *See also* John L. Glover, *Quality Assurance and Medical Stupidity*, 57 AMER. SURGEON 475 (1991) (peer review does nothing to "benefit patients," but effective methods desirable).

57. Richard D. Blondell, *Impaired Physicians*, 20 PRIMARY CARE 209 (1993). Suspension pending treatment may be appropriate when a doctor has the necessary skills but is temporarily unable to exercise them.

58. *See generally*, AMERICAN MEDICAL ASSOCIATION, U.S. MEDICAL LICENSURE STATISTICS AND CURRENT LICENSURE REQUIREMENTS (1990).

59. Kathleen L. Blaner, *Comment: Physician, Heal Thyself: Because the Cure, the Health Care Quality Improvement Act, May Be Worse than the Disease*, 37 CATH. UNIV. LAW REV. 1073, 1079 (1988). *See generally*, *Physician Discipline*, *supra* note 17.

Development of national standards, both to authorize and discipline practitioners, would appear to be logical. Federal attempts to address some of these issues inevitably run into the charge that these regulatory operations are the responsibility of the states.[60] With changes in the economy and the need for a coherent health care policy, a more aggressive federal role could help to resolve lingering problems. Thus, developing a federal policy for physician discipline includes two preliminary considerations. First, one must understand the context for the creation of the federal system;[61] and second, one should relate the values of American federalism to the current status of health care policy.

A. A Healthy Constitution

Many theoretical approaches to comprehending the American federal system have been propounded over the years. Daniel Elazar examines federalism "in the broadest sense of the term" as an "animating and informing principle of the American political system," an "integral federalism."[62] This approach

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60. "The difficulty, from a Federal standpoint, and I used to teach constitutional law, is that the protection of the health and the welfare have been reserved by the 10th and 11th Amendments to the Constitution." *Physician Discipline*, *supra* note 18, at 23 (testimony of Health and Human Services Inspector General Richard Kusserow). But see *Physician Recertification: Hearing Before the Subcommittee on Health of the Committee on Ways and Means*. 101st Cong., 2d Sess. (1990) (a proposal to place Medicare physician re-licensure under federal control) [hereinafter *Physician Recertification*].

61. When considering the founders' arguments for federalism, one should keep in mind Michael G. Collins' observation that "[i]n The Federalist itself, any word resembling 'federalism' is missing." *Whose Federalism?*, 9 CONST. COMMENTARY 75, 84 (1992)

62. Daniel J. Elazar, *Our Thoroughly Federal Constitution*, in HOW FEDERAL IS THE CONSTITUTION? 43-44 (Robert A. Goldwin & William A. Schambra, eds., 1987).

rejects a variety of voguish views throughout American history that persist as the primary avenues for popular and even professional understanding of the Constitution.[63]

Faced with the failures of the Articles of Confederation,[64] the Philadelphia convention developed a "non-centralized" structure to manage the concerns of all.[65] The need for a stronger national government "was inevitable if there were to be any union at all ..."[66] The Constitution of the United States of America, the product of the 1787 convention, incorporated a mixture of both national and federal components.[67] All the delegates to the constitutional convention advocated a stronger

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63. *See id.* at 43. These unhelpful interpretations, in Elazar's view, include "intergovernmental relations" as offered by 20th century "managerial perspectives," the "distribution of powers" advocated by lawyers, and the "grand political struggle" of the states' rights historians of the 19th century. *Id.* at 43-44. "[M]ost contemporary definitions of federalism are little more than generalized descriptions of... divid[ing] governing power between the states and the central government." Martin Diamond, *The Federalist on Federalism: "Neither a National nor a Federal Constitution, but a Composition of Both"*, 86 YALE L.J. 1273 (1977).

64. *See generally*, GORDON S. WOOD, THE CREATION OF THE AMERICAN REPUBLIC 1776-1787 (1969). "The belief that the 1780's, the years after the peace with Britain, had become the really critical period of the entire Revolution was prevalent everywhere during the decade." *Id.* at 393.

65. Elazar, *supra* note 62, at 56-57. Non-centralization differs from decentralization in the former's assumption "that there is no central authority as such," and that power and authority exist at different levels. *Id.* at 56-57. The federal structure of the Constitution would thereby "check despotic tendencies... in both the larger and smaller governments, while preserving the principle of popular government." *Id.* at 56.

66. *Id.* at 52.

67. As James Madison contended, the "proposed Constitution, therefore, ...is, in strictness, neither a national nor a federal Constitution, but a composition of both." THE FEDERALIST PAPERS, No. 39, at 246 (Clinton Rossiter, ed., 1961).

national government.[68] Some, like Alexander Hamilton, insisted on complete elimination of the states as separate entities.[69] The finished document reflected a political compromise among the various parties, however.[70]

The basic elements of the government are more apparent than precise in the language of the Constitution. Even though the federalist structure of the nation is "crystal clear," the balance and locus of power are "ambiguous."[71] James Madison recognized the difficulty of this imprecision as he supported the plan. Inaccuracies in language that resulted from the complexity of the proposed government affected the convention's ability to "delineat[e] the boundary between the federal and State jurisdictions."[72] From this tumultuous beginning, the venture "to form a more perfect Union"[73] has "tried unsuccessfully for nearly

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68. FORREST MCDONALD, NOVUS ORDO SECLORUM: THE INTELLECTUAL ORIGINS OF THE CONSTITUTION 185-87 (1985). Indeed, the states themselves had to be willing to "relinquish major elements of their sovereignty to create a stronger and more effective national government ..." Robert M. O'Neil, *The Separation of Powers in a Federal System*, 37 EMORY L.J. 539, 556 (1988).

69. *See* MURRAY FORSYTH, UNIONS OF STATES: THE THEORY AND PRACTICE OF CONFEDERATION 61-2 (1981); RICHARD B. MORRIS, WITNESSES AT THE CREATION: HAMILTON, MADISON, JAY, AND THE CONSTITUTION 18, 209 (1985).

70. *See* John C. Hueston, *Altering the Course of the Constitutional Convention: The Role of the Committee of Detail in Establishing the Balance of State and Federal Powers*, 100 YALE L.J. 765 (1990). As early as 1819, only thirty years after ratification, the authority of the national government was affirmed by the Supreme Court. McCulloch v. Maryland, 17 U.S. (4 Wheat.) 316 (1819). See also William Jeffrey, Jr., *The Constitution: "A Firm National Government"*, in HOW FEDERAL IS THE CONSTITUTION? *supra* note 62, at 21-22, 30 (disputing "any division whatever of governmental power.")

71. Elazar, *supra* note 62, at 41.

72. THE FEDERALIST PAPERS No. 37, *supra* note 67, at 229.

73. U.S. Const. pmbl.

200 years... to determine precisely how far and how fast we wish[] to take ourselves away from the ramshackle, disarticulated hyper-federalism of the Articles of Confederation."[74]

B. Antibodies and Antinomies

"[T]he case of the patient is carefully examined;... they are unanimously agreed that the symptoms are critical," wrote Madison of the problems the United States faced.[75] While none doubted the importance of changing the Articles, Madison found that the Constitution's opponents could not agree among themselves on either the problems the document posed or an alternative prescription.[76] Even today, the appropriate division between state and federal governments is no less a political venture than at the time the Constitution was originally debated.[77]

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74. David M. Kennedy, *Federalism and the Force of History*, in HOW FEDERAL IS THE CONSTITUTION? *supra* note 62, at 69. *See also* MICHAEL KAMMEN, A MACHINE THAT WOULD GO OF ITSELF: THE CONSTITUTION IN AMERICAN CULTURE 311-12 (1986) (recounting the federalism theme of the Constitution's sesquicentennial); *American Federalism: the Third Century*, 509 ANNALS 9 (1990).

75. THE FEDERALIST PAPERS No. 38, *supra* note 67, at 234.

76. *Id.* at 235. Madison himself remained "ambivalen[t] about various constitutional issues," such that he made "contradictory utterances on different occasions." KAMMEN, *supra* note 74, at 57-8.

77. For a discussion of Anti-Federalist opposition, see generally, JACKSON TURNER MAIN, THE ANTIFEDERALISTS: CRITICS OF THE CONSTITUTION 1781-1788 (1961). Recent commentators range from explicitly political to scholarly ventures. *See generally*, BARRY GOLDWATER, THE CONSCIENCE OF A CONSERVATIVE (1960); Lino A. Graglia, *From Federal Union to National Monolith: Mileposts in the Demise of American Federalism*, 16 HARVARD J. L. & PUB. POL'Y 129 (1993); Daniel J. Elazar, *The New Federalism: Can the States Be Trusted?*, 35 THE PUBLIC INTEREST 89 (1974). In twentieth century political terms, the objections come from individuals that view federalism as preventing the rise of explicitly socialist policies in America. Frank J.

Rather than offering a rule of law to be applied from case to case, federalism represents a collection of values that are necessarily flexible for the role of governance.[78] Federalism values are mixtures of both political and managerial tendencies. The political features of the Constitution's design assist in the protection of individual liberty.[79] Maintaining several levels of government provides opportunities for more citizen involvement in self-government. The system simultaneously prevents factions and less mainstream groups from dominating other citizens, because

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Thompson, *New Federalism and Health Care Policy: States and the Old Questions*, 11 J. HEALTH POL., POL'Y & LAW 647, 648 (1986) (citing T.J. Lowi, *Why Is There No Socialism in the United States? A Federal Analysis*, in THE COSTS OF FEDERALISM (R.T. Golembiewski & A. Wildavsky, eds., 1984). To the extent that modern criticisms of federal over state action rely on an originalist approach, they neglect the pervasive uncertainty of the period as to the meaning of the Constitution. "No issue involving constitutional interpretation during these decades [following ratification and the Bill of Rights] was more delicate or persistent than the nature of the federal Union in general and the problem of state sovereignty in particular." KAMMEN, *supra* note 75, at 51. *See also* Paul Brest, *The Misconceived Quest for Original Understanding*, 60 B.U. L. REV. 204 (1980).

78. *Cf.* Robert F. Nagel, *Federalism as a Fundamental Value: National League of Cities in Perspective*, 1981 SUP. CT. REV. 81; David M. O'Brien, *Federalism as a Metaphor in the Constitutional Politics of Public Administration*, 49 PUB. ADMIN. REV. 411 (1989). *See also* James Edwin Kee & John Shannon, *The Crisis and Anticrisis Dynamic: Rebalancing the American Federal System*, 52 PUB. ADMIN. REV. 321 (1992) (suggesting that a crisis, e.g., war, increases demands for national action); James L. Sundquist, *American Federalism: Evolution, Status, and Prospects*, 19 URB. LAW. 701 (1987) (an "unceasing... debate and political struggle" with controversies that "exploded in a constitutional crisis").

79. Liberty is enhanced by the diffusion of power among several centers of authority. *See* Note, *Taking Federalism Seriously: Limiting State Acceptance of National Grants*, 90 YALE L.J. 1694, 1699 (1981)[hereinafter *Taking Federalism Seriously*]; Note, *Federalism, Separation of Powers, and Individual Liberties*, 40 VAND. L. REV. 1353 (1987).

the former are more likely to be restricted to regional or smaller levels.[80]

On the managerial side, a federal system enables the smaller governmental entities to establish programs that meet a particular region's more selective needs.[81] Sensitivity and responsiveness to constituents' concerns have a basic political component in their legitimizing effects on government. The necessity for increased responsiveness in turn provides an opportunity for experimentation, with a variety of programs simultaneously meeting similar needs at different locations.[82] Favored by the rise of administrative agencies as primary sources of governance, managerial components animate current approaches to understanding and analyzing federalism.[83]

The managerial and political values do not function as attributes that are independent from each other within the

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80. *Taking Federalism Seriously*, *supra* note 79, at 1700. *See also* ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS, CITIZEN PARTICIPATION IN THE AMERICAN FEDERAL SYSTEM (1980).

81. *Id., Taking Federalism Seriously.*

82. *Id. See also* Thad L. Beyle, *The Governor as Innovator in the Federal System*, 18 PUBLIUS 131 (1988). The now-classic statement of this position comes from Justice Brandeis: "It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." New State Ice Co. v. Liebermann, 285 U.S. 262, 310-11 (1932) (Brandeis, J. dissenting). Regional experimentation also decreases the likelihood that "a boring sameness" will envelop the nation. *Taking Federalism Seriously*, *id.*

83. *See* JEREMY RABKIN, JUDICIAL COMPULSIONS: HOW PUBLIC LAW DISTORTS PUBLIC POLICY 243-44 (1989). Federalism is "now characterized as more costly, less effective, less responsive, and less accountable." Laurence J. Aurbach & Ross D. Davis, *Federalism for the Third Century?*, 19 URB. LAW. 445 (1987). Federal administrative action also presents a problem for analyzing preemption of state laws. *See generally*, Benjamin W. Heineman, Jr. & Carter G. Phillips, *Federal Preemption: A Comment on Regulatory Preemption after Hillsborough County*, 18 URB. LAW. 589 (1986).

Constitution. They mutually affect and reinforce the role of democratic governance in the United States.[84] The political considerations of federalism, in conjunction with the democratizing pulls of the electorate, play an important role in health care policy.[85] Attempts to develop a workable health policy within the

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84. At the same time he was defending the nationalizing structure of the Constitution, Madison asserted that the separation of powers within the national government's "three great provinces" -- legislative, executive, and judicial -- would endure an "obscurity" that would "puzzle the greatest adepts in political science." THE FEDERALIST PAPERS No. 37, *supra* note 67, at 228. One of the more controversial Supreme Court cases on federalism, supported the principle that federalism is a function of the nation's very structure. The protected sovereignty of the states lies "in the shape of the constitutional scheme rather than in predetermined notions of sovereign power...." Garcia v. San Antonio Metropolitan Transit Authority, 469 U.S. 528, 550 (1985). Through this shape, "restraints on federal power over the States inhere principally in the workings of the National Government itself, rather than in discrete limitations on the objects of federal authority." *Id.* at 552. The dissenting "defenders" of federalism rejected any reliance on a coequal branch's authority: "Nor is so much as a dictum of any court cited in support of the view that the role of the States in the federal system may depend upon the grace of elected federal officials, rather than on the Constitution as interpreted by this Court." *Id.* at 560-1 (Powell,J., dissenting). *Cf.* National League of Cities v. Usery, 426 U.S. 833 (1976)(overruled by Garcia v. San Antonio Metropolitan Transit Authority, 469 U.S. 528 (1985)); and Fry v. U.S., 421 U.S. 542 (1975). *See also* Carol Lynn Tebben, *Is Federalism a Political Question? An Application of the Marshallian Framework to Garcia*, 20 PUBLIUS 113 (Wint. 1990). At issue in *Garcia* was a federal labor law's application to a state governmental entity. The core concern of this article is the subject matter for federal regulation, and it is to that question that managerial and political considerations apply. Congress may not violate other constitutional provisions in implementing its policies, however.

85. *See, e.g.* MORONE, *supra* note 4, at 253-4. The health care changes in the mid-1960s shared many attributes with the programs President Franklin Roosevelt adopted in the 1930s to lift America out of the Depression. President Lyndon Johnson "was a true disciple on the New Deal. And what, after all, was the Great Society but a Texas-style version of the New Deal turned loose... on the conquest of poverty, deprivation, and suffering in all their still-lingering forms?" ELLIOT RICHARDSON, THE CREATIVE BALANCE: GOVERNMENT, POLITICS, AND THE INDIVIDUAL IN AMERICA'S THIRD CENTURY 125 (1976).

country are predominantly managerial, however. Despite the misperception of public attention, the states have recently been initiating more aggressive responses in their own policies.[86] Yet "no serious scholar in the field" advocates the development of a "non-centralized approach to health policy."[87] The two recent major initiatives from Washington have emphasized a more unified national plan for health policy.[88]

Federal law already is aimed at the "increasing occurrence of medical malpractice and the need to improve the quality of medical care [that] have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State."[89] More federal involvement in the plans and processes of physician licensing and discipline may be a necessary step to assuring a pool of quality physicians. If no explicit constitutional

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86. *See* Turque, et.al., *supra* note 18. *But see* Russell L. Hanson, *Defining a Role for States in a Federal Health Care System, 36* AMER. BEHAV. SCI. 760 (1993) (a "patchwork of programs" continues questions about equity).

87. Thompson, *supra* note 77, at 647. The gaps between state and federal governments in terms of the "commitment, capacity, and progressivity" in health policy have declined, but "substantial variation" remains a concern. *Id.* at 665.

88. President Ronald Reagan's "New Federalism" would have placed Medicaid at the national level, alongside its companion program Medicare, while returning other welfare programs to the states. See Irving Louis Horowitz, *From the New Deal to the New Federalism*, 42 AM. J. OF ECON. AND SOC. 129 (1983). Horowitz raised several federalism values in discussing his overall concerns about the plan. *Id.*, 146-7. The Clinton plan obviously shifts much of the health care agenda to the national level. A major Clinton theorist, Alice Rivlin, supports a process similar to the Reagan program. *See* Alice M. Rivlin, *A New Vision of American Federalism*, 52 PUBLIC ADMIN. REV. 315 (1992). She would shift social insurance, including health, to the federal government while a "productivity agenda" -- education, work skills, and infrastructure -- would be transferred to the states. *Id. See also* ALICE M. RIVLIN, REVIVING the AMERICAN DREAM: The ECONOMY, THE STATES AND THE FEDERAL GOVERNMENT (1992); Robert M. Solow, *Dr. Rivlin's Diagnosis & Mr. Clinton's Remedy*, N.Y. REV. OF BOOKS, Mar. 25, 1993, at 12.

89. 42 U.S.C. § 11101(1) (1988).

barrier prevents federal action on the subject, then the question remains as to whether the values of federalism support the development of a national licensure system, or whether Congress should utilize alternative means to ensure a competent community of physicians.

IV. CURING FEDERAL LAW

A. Doctors in the House and Senate

Efforts at more extensive federal involvement in physician regulation tend to flounder in congressional committees and never reach the floor of either house. Legislation introduced in recent years covered various aspects of licensing and discipline, including fraud, discrimination against foreign medical graduates, and state residency concerns.[90] Another bill recommended recertification, on a national level, of physicians involved in the Medicare and Medicaid programs through periodic reexamination.[91] The author

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90. H.R. 2113, 102d Cong., 1st Sess. (1991) (fraud); H.R. 2092, 101st Cong., 1st Sess. (1989) (fraud); S. 2934, 101st Cong., 2d Sess. (1990) (licensing and discipline generally); S. 475, 102d Cong., 1st Sess. (1991) (discrimination); S. 2515, 101st Cong., 2d Sess. (1990) (discrimination); H.R. 196, 103d Cong, 1st Sess. (1993) (fees and disciplinary boards). *See also* GRAD & MARTI, *supra* note 25, at 110-12 (describing S. 3585, 93d Cong., 2d Sess. (1974)). Compare this approach with Grad and Marti's recommendation for disciplining physicians in light of the nature of the policy interest violated, generally either protection of health and safety or economic exploitation. *Id.* at 7. The area of economic exploitation has achieved greater significance; regulations were developed to limit Medicare reimbursements for physician referrals to labs that they owned. 42 C.F.R § 411.350 (1992).

The federal government has not chosen to establish a licensing system for its own employees, adopting instead licensure in any state system as a prerequisite to employment. *See, e.g.*, 10 U.S.C. § 1094 (1988) (armed forces physicians, dentists, psychologists, nurses, and others as specified).

91. H.R. 4464, 101st Cong., 2d Sess. (1990). Most current federal law on licensing relates to the Medicaid and Medicare programs. These programs served as a catalyst for more federal interest in the health care credentialing

of the bill recognized that "it is easier to deny an incompetent physician a new license, than it is to remove one."[92] In lieu of accepting these bills, two new bodies have been established to study the issues and to advise policy makers.[93]

Congress has responded to some problems through the Health Care Quality Improvement Act of 1986 (HCQIA).[94] This legislation encouraged professional self-discipline through increased involvement of peer review organizations (PROs) in the assessment of physicians and responded to personal liability concerns stemming from the review process.[95] The act also mandated reporting requirements for state medical boards and PROs, as well as parallel provisions imposing a duty to inquire on the part of hospitals.[96] The information collected under the

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process. Blaner, *supra* note 59, at 1087. Federal law in this context excludes physicians from participating in programs if their licenses have been revoked or suspended by a state, as well as by committing fourteen other acts listed in the statute, including fraud, drug conviction, patient abuse, loan default. 42 U.S.C. §1320a-7 (1988).

92. *See Physician Recertification*, *supra* note 60 at 4 (statement of Representative Pete Stark).

93. Health Professions Education Extension Amendments of 1992, Title III, P.L.No. 102-408, 106 Stat. 1992 (1992). The Advisory Council on Graduate Medical Education assists the Secretary of Health and Human Services and Congress on questions of supply, distribution and education of physicians. The National Advisory Council on Medical Licensure advises the Secretary on licensing and credentialing concerns.

94. 42 U.S.C. § 11101-52 (1988).

95. 42 U.S.C. § 11111-15 (1988). HCQIA extended immunity from suit to individuals who testify before and who judge in the PRO process. "The real essence of HCQIA is the immunity it affords." Karen Sandrick, *Two Years and Running*, HOSPITALS, February 5, 1993 at 44 (quoting Ila Rothschild, assistant general counsel for the American Hospital Association).

96. 42 U.S.C. §§ 11132-37. *But see* Michele Saludo & Rebecca Blumenstein, *Medical Examiner: Probe Doc Jointly*, NEWSDAY Oct. 22, 1993 at 28 (dangerous physician employed because data bank check not mandatory).

auspices of HCQIA is entered into the National Practitioner Data Bank (NPDB).[97] Hospitals can use the information contained in the data bank as one factor on which to base a credentialing decision.[98]

Early assessments of the HCQIA legislation recognized several gaps. PROs exhibit a broad failure in identifying substandard practices by physicians.[99] The act does not require reporting of all adverse information, excluding for example disciplinary sanctions under thirty days.[100] Similarly, first- year information indicates that licensure actions appear to be underrepresented in the NPDB because of the act's limited reporting requirements.[101] Variations persist from state to state

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97. 42 U.S.C. § 11131-37 (1988). The data bank is not limited to information regarding physicians. See G. Birkholz, *Implications of the National Practitioner Data Bank for Nursepractitioners*, 16 NURSE-PRACTITIONER 40 (August 1991). A consumer-driven guide to questionable physicians was developed in 1990 by the Public Citizen Health Research Group. INGRID VANTUINEN, PHYLLIS MCCARTHY & SIDNEY WOLFE, 9479 QUESTIONABLE DOCTORS DISCIPLINED BY STATES OR THE FEDERAL GOVERNMENT (1990).

98. Sandrick, *supra* note 95, at 45. Hospital administrators see a report's contents "merely as a red flag" which "duplicate[s] information hospitals collect in other ways." *Id.*

99. Haya R. Rubin, et al., *Watching the Doctor-Watchers: How Well Do Peer Review Organization Methods Detect Hospital Care Quality Problems*, 267 JAMA 2349 (1992) (study finding a twelve percentage point difference in identifying questionable care). Compare Evelyn M. Kuhn, et al., *The Relationship of Hospital Characteristics and the Results of Peer Review in Six Large States*, 29 MEDICAL CARE 1028 (Oct. 1991) (linking resources, training, and equipment to quality of care assessments).

100. *See* Sandrick, *supra* note 95, at 45 (doctors bargaining for lighter sanctions).

101. *See* Fitzhugh Mullan, et al., *The National Practitioner Data Bank: Report from the First Year*, 268 JAMA 73, 76 (1992). The Federation of State Medical Boards, which also tracks disciplinary acts, estimated twice as many reports as the NPDB files indicated. The latter registers only discipline concerning medical conduct directly.

in defining inappropriate behavior, thus potentially relevant, sanctionable behavior may not be listed.[102] Reporting also includes potentially extraneous data that do not always reflect on competence, such as malpractice payments.[103]

If achieving a qualified, nationwide community of physicians is a top priority for the country -- the interest in obtaining quality uniformly is certainly strong[104] -- then the lack of coordination among the states should yield to the broader demand, irrespective of the health insurance reform outcome.[105] Proposals inevitably crash headlong into the criticism that the states will see such efforts as an ominous attempt to create "Federal medical licensure... [even if] prompted by the best of intentions."[106] Yet the concerns of these critics sound more like

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102. Blaner, *supra* note 59, at 1079; Christopher S. Morter, *The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting?* 74 VA. L. REV. 1115, 1139 (1988).

103. "The relationship between malpractice payments and culpability is far less certain than that which exists between adverse actions and medical incompetence." Mullan, *supra* note 101, at 73, 78.

104. Comparably, the availability of a specific service varies from state to state, but there is no apparent "rationale to justify restriction to those residents in other states who may be unwell." Susan Bartlett Foote, *Comment*, in FEDERALISM: STUDIES IN HISTORY, LAW, AND FEDERAL POLICY 75-76, (H.N. Scheiber, ed., 1988).

105. A proponent of state licensing condemned the results fourteen years later as "'provincialism run riot.'" Each state created its own systems, apart from all the others. Derbyshire, *supra* note 22, at 151 (quoting William Osler, AEQUANIMITAS 276 (1944). One author has suggested that a movement towards some aspects of regulatory consistency has already taken place within the states' court systems. In private malpractice litigation, specialty-certified physicians must demonstrate medical care equivalent to that provided elsewhere by similarly certified colleagues. Edward N. Beiser, *Medical Care, Public Policy, and Contemporary Federalism*, in FEDERALISM, *supra* note 104, at 63, 68-9.

106. *Physician Discipline*, *supra* note 17, at 32 (statement of James R. Winn, executive vice president, Federation of State Medical Boards of the United States, Inc.). *See also id.* at 21 ("perceived by some as an initial effort to shift

stagnant conceptions of federalism as a bright line rule of law, rather than federalism as a principle for the role of governance. By focusing on the interconnected responsibilities between the state and federal governments, federalism values can help to shape the policy that is implemented.

B. Alternative Treatments

Section A discussed legislation, both enacted and proposed, that came from both parties in Congress. Thus, Democrats and Republicans share the desire for reform. The remaining dilemma is identification of the policy that best accounts for the political and managerial values of federalism. What follows are sketches of three alternative plans, highlighting the pros and cons of each.

1. Nationalization

Under one policy option, the federal government could mandate across-the-medical-board consistency in licensing and discipline by developing and implementing federal guidelines.[107] This can be done without preempting all state law.[108] First, a

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the focus to a federal system," Peyton E. Weary, president, American Board of Medical Specialties). Medical community opposition to national licensing over traditional state powers may only reflect a purely self-interested motivation. Medical malpractice litigation and insurance, equally a traditional state responsibility with licensing, should be regulated federally according to the AMA. *See Federal Incentives*, *supra* note 12, at 189.

107. Kissam recommends a federal agency that would engage in accreditation of training programs and credentialing of practitioners on the basis of innovation and quality. Kissam, *supra* note 2, at 84.

108. When the national government acts, it *may* be preempting, via the Supremacy Clause, state regulation of these same areas. "This Constitution, and the Laws of the United States which shall be made in pursuance thereof... shall be the supreme Law of the Land...." U.S. CONST. art. VI, §2. The question often involves a careful look at the state and federal laws in question, including

national policy need only be for *physicians*, not for other health professions.[109] Second, balancing traditional state interests in licensing practices can be accomplished by allowing, for example, experimentation with alternative health care providers such as midwives, physician extenders, or holistic and homeopathic practitioners.[110]

The significant advantage of this proposal is the opportunity to stabilize the discipline and sanction process for licenses nationwide, a quality goal that is highly desirable. Standards for discipline would be similar everywhere in the country. Suspension or revocation of a license would bar employment anywhere in the country for the appropriate period. From a managerial viewpoint, however, federal responsibility makes little sense.

Funding and personnel for these operations would be removed from state auspices. Federal boards would assume responsibility for case processing, but they would need to be geographically stationed to assure responsiveness and effectiveness. Placing disciplinary boards in every state but identifying them as federal entities replicates the system currently in place in many

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the intent of the legislatures. A state law that explicitly conflicts with a federal one will be nullified, but the substantiality of the conflict is not always apparent. Where two laws can coexist, however, the search involves locating an intent on the part of the federal government to occupy the entire field and thereby to exclude all state regulation. *See* Pacific Gas & Electric v. State Energy Resources Conservation Commission, 461 U.S. 190 (1983).

109. *Cf.* Kissam, *supra* note 2, at 84 (proposing an alternative federal plan for physicians and physician specialists). Kissam adds that limiting the program may also serve administrative and political considerations. *Id.*

110. *Cf. id.*, *supra* note 2, at 84-85 (implementing "not new regulation but for a new competition between federal, state and private regulatory systems"). *See generally* Q. W. Smith, C. E. Fasser & J.D. Holcomb, *Credentialing by Legislative Fiat: Implications for the Allied Health Professions*, 20 J. OF ALLIED HEALTH 157 (1991) (allowing unlicensed physicians to serve as physician's assistants); Note, *The Legal Status of Physician Extenders in Iowa: Review, Speculations, and Recommendations*, 72 IOWA L. REV. 215 (1986). Other regulations might address working conditions, such as hours, procedures or equipment.

ways, without the advantage of proximity to the population for basic legislative policy decisions. Thus a national licensing and discipline policy seems to create the most extensive disruption of the current structure.

2. Interstate Restriction

A second possibility for federal involvement would be to sanction, either civilly or criminally, physicians crossing state borders in order to practice in another state while they have affected licenses. The act of crossing a state border is the classic basis for federal legislation under the Commerce Clause.[111] A policy on these grounds does not undermine current federalism notions as much as the policy suggested in subsection one. Consequently, even the ardent supporters of bright line federalism could prescribe a national policy under these conditions.

This approach leaves the current state system completely intact and avoids a major disruption in licensing and discipline procedures. It targets directly those individuals whose records are unacceptable. Unfortunately, it minimizes potential gains in establishing higher quality nationwide because it ignores state-by-state inconsistencies and other problems. Another drawback develops under due process concerns: physicians who switch states while under investigation. In New York, for example, disciplinary proceedings are closed until a final determination is made.[112] Unless the policy extends to barring individuals who are merely under investigation from crossing state lines to continue practicing, a constitutionally dubious proposition, a large class of individuals could avoid any consequences.

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111. U.S. CONST., art. 1 §8.

112. See Doe v. Office of Professional Medical Conduct of the New York State Department of Health, 81 N.Y.2d 1050, 601 N.Y.S.2d 573, 619 N.E.2d 651 (1993).

3. Suspension Reciprocation

A third version of federal policy mandates that license suspensions and revocations automatically be reciprocal. This approach would be tied immediately to state laws. Most states maintain endorsement provisions for granting out-of-state license holders an equivalent credential. When a license is revoked or suspended in one state, however, a parallel action in another may not occur for a variety of reasons. These include cost, basis of initial sanction, or lack of information about the earlier discipline, arguably less a concern with reporting under the HCQIA.

A reciprocity-based policy has an advantage in its continuity with state responsibility for health and safety regulation. It maintains and reinforces the present role of the states. Aside from basic procedural requirements and perhaps some substantive concerns, states would have a relatively free hand in drafting legislation. Like the first policy option mentioned, reciprocity would provide more stability across the country, even though some states might not themselves focus on identical acts as inappropriate. Federal implementation, furthermore, could be through an indirect process that conditioned state receipt of federal funds on the adoption of the provision.[113]

Discipline reciprocity would eliminate the delays and disinterest of sister states by triggering an interstate suspension or revocation, but it would maintain local responsibility. This policy, furthermore, would extend a comparable constitutional cornerstone to medical licensing: the Full Faith and Credit Clause.[114]

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113. The policy promoted must be related to the spending program to which it is attached. *See* South Dakota V. Dole, 483 U.S. 203 (1987) (conditioning federal highway funds on state's minimum drinking age constitutional despite Twenty-first Amendment). *Cf.* GRAD & MARTI, *supra* note 26, at 10 (it is "possible and desirable" to use conditions on the receipt of federal funds).

114. "Full faith and Credit shall be given in each State to the public Acts, Records, and Judicial Proceedings of every other State. And the Congress may by general Laws prescribe the Manner in which such Acts, Records and Proceedings shall be proved, and the Effect thereof." U.S. CONST., art. IV §1.

Although the relevant provisions of the clause apply to acts, records, and judicial proceedings, extension of the idea to licensing boards seems worthwhile.[115]

V. THE FOLLOW-UP VISIT

Assuring that treatment will be provided, regardless of a person's income or wealth, offers little improvement in the health of the citizens if the doctors should not be practicing at all. Physician discipline is just one area in which new ideas need to be developed in order to combat a long-standing problem. Provided above are a few ways of thinking about discipline issues in the context of the U.S constitutional structure. Proactive federal policies to establish a qualified community of medical practitioners inevitably will tread upon traditional notions of state sovereignty; however, federal legislation need not replace state authority. A politically and economically viable conception of federalism must distinguish between extremes at both the hyper-federal and centralized interpretations of state-federal structure and work toward effective public policies.

115. "Indeed, there are few clauses of the Constitution, the merely literal possibilities of which have been so little developed as the full faith and credit clause." CONGRESSIONAL RESEARCH SERVICE, THE CONSTITUTION OF THE UNITED STATES: ANALYSIS AND INTERPRETATION, S. Doc. No. 16, 99th Cong., 1st Sess. 870 (1987).